Mental Health Referral Form

Scarborough Academic Family Health Team

Tel: 416-690-5180 | Fax: 416-690-5182

Patient Information

First Name:

Last Name:

DOB: (DD/MM/YYYY) Gender:

Address:

Hm Phone: Cell#:

HC#:

Email:

Clinic / Physician Information:

Family Physician:

Tel #: Fax:

Consent to leave message ☐ YES ☐ NO

Consent to email ☐ YES ☐ NO

Medication

Relevant Medical History:

Allergies:

Reports/Diagnostics: *Please attach all relevant reports:*

☐ Lab Reports ☐ Consultant Reports

☐ Diagnostic Imaging ☐ Discharge Summaries Other

☐ (specify):

Willing to attend Group Programs? ☐ YES ☐ NO

If the answer is NO - Provide reason

☐ **Individual Counselling** ☐ Resource Counselling

Addiction

Eating Disorder

Mood Disorder

Relationships

School

Seniors

Stress

Trauma

Personality Disorder

THIS SECTION MUST BE ANSWERED OR IT WILL BE RETURNED

History of :

Psychosis	☐ YES	☐ NO
Suicide Attempt(s)	☐ YES	☐ NO
Suicidal Ideation	☐ YES	☐ NO
Self-Harming	☐ YES	☐ NO
Sleeping Issues	☐ YES	☐ NO
Under psychiatrist care	☐ YES	☐ NO
Referral to psychiatrist	☐ YES	☐ NO
Hospitalization - MH reason	☐ YES	☐ NO

(If yes please attach discharge summary or consult notes

Involvement with the Legal System ☐ YES ☐ NO

Preferred Language ☐ English ☐ Other

If other than English please arrange your own interpreter

Risk Level (the impact it has on the client's life)

Please include PHQ/GAD if done

Comments/Details: MORE INFORMATION WILL HELP US ASSIGN THE CLIENT WITH THE APPROPRIATE THERAPIST